CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

ELIGIBILITY INFORMATION

Programs

The Department for Social Insurance, Division of Field Services local office staff have primary responsibility for accepting and processing applications for benefit programs administered by the Cabinet for Human Resources, Department for Social Insurance. These programs, which include eligibility for Medicaid, include:

AFDC (Aid to Families with Dependent Children)

AFDC Related Medical Assistance

State Supplementation of the Aged, Blind, or Disabled

Aged, Blind, or Disabled Medical Assistance

Refugee Resettlement Programs

Any individual has the right to apply for Medicaid and have eligibility determined. Persons wanting to apply for Medicaid benefits should be referred to the local Department for Social Insurance, Division of Field Services office in the county in which they live. Persons unable to visit the local office may write or telephone the local office for information about making application. For most programs, a relative or other interested party may make application for a person unable to visit the office.

In addition to the programs administered by the Department for Social Insurance, persons eligible for the federally administered Supplemental Security Income (SSI) program also receive Medicaid through the Kentucky Medical Assistance Program. Eligibility for SSI is determined by the Social Security Administration. Persons wanting to apply for SSI should be referred to the Social Security Administration office nearest to the county in which they live. The SSI program provides benefits to individuals who meet the federal definitions of age, blindness, or disability, in addition to other eligibility requirements.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

ELIGIBILITY INFORMATION

MAID Cards

Medical Assistance Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month-to-month eligibility period.

Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend down" case receive one MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend down" eligibility period.

MAID cards may show a retroactive period of eligibility. Depending on the individual circumstances of eligibility, the retroactive period may include several months.

Duplicate MAID cards may be issued for individuals whose original card is lost or stolen. The recipient should report the lost or stolen card to the local Department for Social Insurance, Division of Field Services worker responsible for the case.

Verifying Eligibility

The local Department for Social Insurance, Division of Field Services staff may provide eligibility information to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564-6885 may also verify eligibility for providers.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(FRONT OF CARD)

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Medical Insurance Code indicates type of insurance coverage.

Eligibility period is the month, day and year of KMAP eligibility represented by this card.
" From" date is first day of eligibility of this card.
"To" date is the day eligibility of this card ends and is not included as an eligible day.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

Date card was issued

MEDICAL ASSISTANCE IDENTIFICATION CARD
COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES

ELIGIBILITY PERIOD
FROM: 06 - 01 - 85
TO: 07 - 01 - 85

CASE NUMBER
037 C 000123456

CASE NAME AND ADDRESS

ISSUE DATE:
12-27-88

Jane Smith
400 Block Ave.
Frankfort, KY 40601

ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS

SEE OTHER SIDE FOR SIGNATURE MAP 520A REV 6/88

Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	SEX	DATE OF BIRTH MO-YR	INS.
Smith, Jane	1234567890	2	0353	M
Smith, Kim	2345678912	2	1284	M

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For K.M.A.P. Statistical Purposes

Date of Birth shows month and year of birth of each member . Refer to this block when providing services limited to age.

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for K.M.A.P. benefits.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-A

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(BACK OF CARD)

Information to Providers. Insurance Identification codes indicate type of insurance coverage as shown on the front of the card in "Ins." block.

This card certifies that the person(s) listed hereon is /are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources
Department for Social Insurance
Division of Medical Assistance
Frankfort, KY 40621

Insurance Identification

A Part A Medicare Only
B Part B Medicare Only
C Both Parts A & B Medicare
D Blue Cross Blue Shield
E Blue Cross Blue Shield Major Medical
F Private Medical Insurance
G Champus
H Health Maintenance Organization
J Other and or Unknown
L Absent Parent's Insurance
M None
N United Mine Workers
P Black Lung

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, durg stores, physicians, dentists, nursing homes, intermediate care facilities. Independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 205.624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.
Federal law provides for a $10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

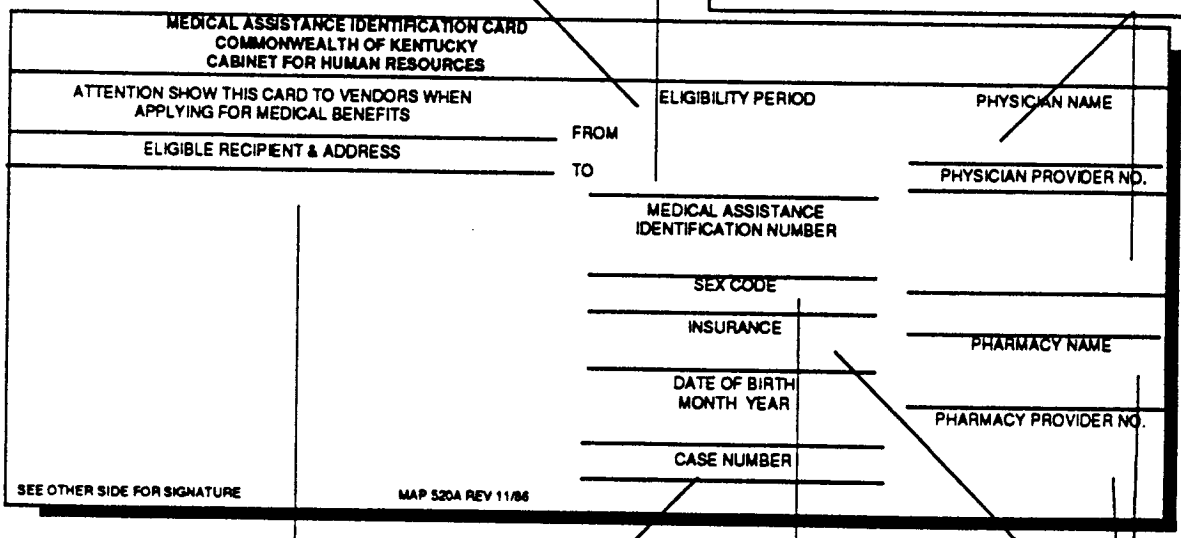
KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(FRONT OF CARD)

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Name and provider number of Lock-In physician. KMAP payments will be limited to this physician (with the exception of emergency services and physician referral unless otherwise authorized by the KMAP.



Name and address of member eligible for Medical Assistance benefits. All eligible individuals in the Lock-In Program will receive a separate card.

Currently Left Blank

Insurance Code

Department for Social Insurance case number. This is **NOT** the Medical Assistance Identification Number.

Name, address, and provider number of Lock-In pharmacy. Payment for pharmacy services is limited to this pharmacy, except in cases of emergency. In case of emergency, payment for covered services can be made to any participating pharmacy, provided notification and justification of the service is given to the lock-in program.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)

Information to Providers, including procedures for emergency treatment, and identification of insurance as shown on the front of the card in "Ins." block.

ATTENTION

This card certifies that the person listed on the front of this card is eligible during the period indicated for current benefits of the Kentucky Medical Assistance Program. Payment for physician and pharmacy services is limited to the physician and pharmacy appearing on the front of this card.

In the event of an emergency, payment can be made to any participating physician or participating pharmacy rendering service to this person if it is a covered service. The patient is not restricted with regard to other services; however, payment can only be made within the scope of Program benefits. Recipient temporarily out of state may receive emergency medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance. Questions regarding scope of services should be directed to the Lock-In coordinator by calling 502-564-5560.

You are hereby notified that under State Law KRS 205 624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Insurance Identification

A Part A Medicare Only
B Part B Medicare Only
C Both Parts A & B Medicare
D Blue Cross Blue Shield
E Blue Cross Blue Shield Major Medical
F Private Medical Insurance
G Champus
H Health Maintenance Organization
J Other and or Unknown
L Absent Parent's Insurance
M None
N United Mine Workers
P Black Lung

I have read the above information and agree with the procedures as outlined and explained to me

Signature of Recipient or Representative

Date

RECIPIENT OF SERVICES

Federal law provides for a $10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(FRONT OF CARD)

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day. KenPAC services provided during this eligibility period must be authorized by the Primary Care physician listed on this card.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

Names of members eligible for KMAP. Persons whose names are in this block have thePrimary Care provider listed on this card.

Date card was issued

MEDICAL ASSISTANCE IDENTIFICATION CARD
COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES

ELIGIBILITY PERIOD		CASE NUMBER
FROM:	06 - 01 - 85	
TO:	07 - 01 - 85	037 C 000123456

CASE NAME AND ADDRESS

ISSUE DATE:
12-27-88

Jane Smith
400 Block Ave.
Frankfort, KY 40601

ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS

SEE OTHER SIDE FOR SIGNATURE MAP 520K (6/86)

Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	SEX	DATE OF BIRTH MO-YR	INS.
Smith, Jane	1234567890	2	0353	M
Smith, Kim	2345678912	2	1284	M

KENPAC PROVIDER AND ADDRESS

Warren Peace, M.D.
1010 Tolstoy Lane
Frankfort, KY 40601

502-346-9832
PHONE

Case name and address show to whom the card is mailed. This person may be that of a relative or other interested party and may not be an eligible member.

Name, address and phone number of the Primary Care Physician.

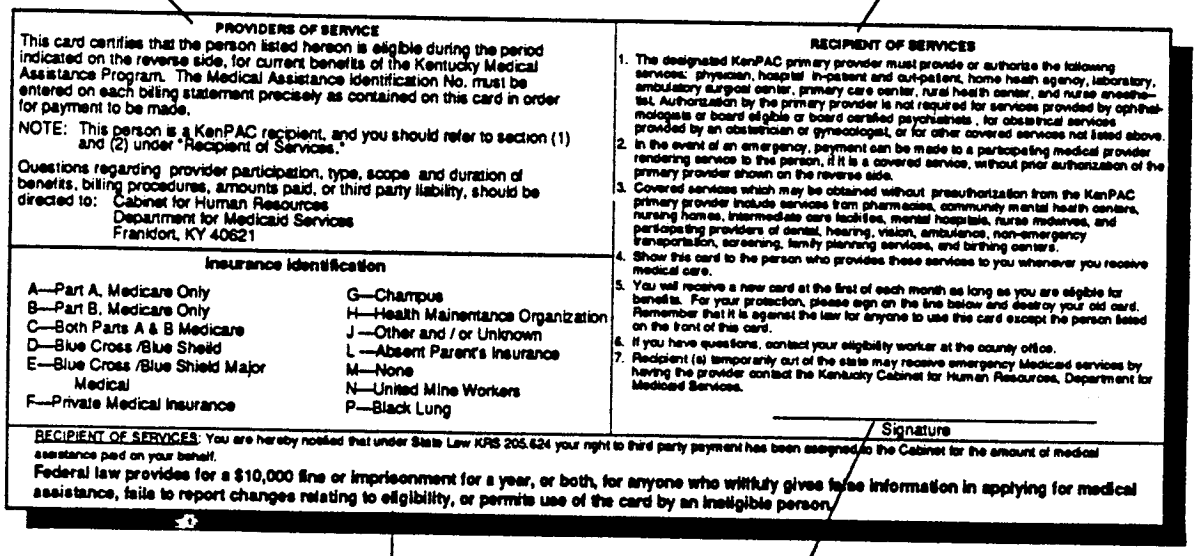
Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(BACK OF CARD)

Information to Providers. including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through the KenPAC system.



PROVIDERS OF SERVICE

This card certifies that the person listed hereon is eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

NOTE: This person is a KenPAC recipient, and you should refer to section (1) and (2) under "Recipient of Services."

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources
Department for Medicaid Services
Frankfort, KY 40621

Insurance Identification

A—Part A. Medicare Only
B—Part B. Medicare Only
C—Both Parts A & B Medicare
D—Blue Cross /Blue Shield
E—Blue Cross /Blue Shield Major Medical
F—Private Medical Insurance
G—Champus
H—Health Mainentance Organization
J—Other and / or Unknown
L—Absent Parent's Insurance
M—None
N—United Mine Workers
P—Black Lung

RECIPIENT OF SERVICES

1. The designated KenPAC primary provider must provide or authorize the following services: physician, hospital in-patient and out-patient, home heath agency, laboratory, ambulatory surgical center, primary care center, rural health center, and nurse anesthetist. Authorization by the primary provider is not required for services provided by ophthalmologists or board eligible or board certified psychiatrists , for obstetrical services provided by an obstetrician or gynecologist, or for other covered services not listed above.
2. In the event of an emergency, payment can be made to a participating medical provider rendering service to the person, if it is a covered service, without prior authorization of the primary provider shown on the reverse side.
3. Covered services which may be obtained without preauthorization from the KenPAC primary provider include services from pharmacies, community mental health centers, nursing homes, intermediate care facilities, mental hospitals, nurse midwives, and participating providers of dental, hearing, vision, ambulance, non-emergency transportation, screening, family planning services, and birthing centers.
4. Show this card to the person who provides these services to you whenever you receive medical care.
5. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below and destroy your old card. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.
6. If you have questions, contact your eligibility worker at the county office.
7. Recipient (s) temporarily out of the state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.

Signature

RECIPIENT OF SERVICES: You are hereby noticed that under State Law KRS 205.624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B) CARD

(FRONT OF CARD)

Eligibility period is the month, day and year of QMB eligibility represented by this card. " From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

Medical Insurance Code indicates type of insurance coverage.

Red

Blue

LIMITED MEDICAID FOR QUALIFIED MEDICARE BENEFICIARIES
IDENTIFICATION CARD
COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES

ELIGIBLE RECIPIENT AND ADDRESS	ELIGIBILITY PERIOD	COVERAGE IS LIMITED TO:
Jane Smith 400 Block Ave. Frankfort, KY 40601	FROM: TO: MEDICAID QMB ID. NO. SEX CODE INSURANCE ID. DATE OF BIRTH MONTH/YEAR	★ MEDICARE PART B PREMIUMS ★ MEDICARE CO-INSURANCE ★ MEDICARE DEDUCTIBLES SEE REVERSE SIDE FOR ADDITIONAL INFORMATION PLEASE SIGN IMMEDIATELY
ATTENTION: SHOW THIS CARD TO VENDORS WHEN SEEKING MEDICAL CARE		
MAP 520-C REV (1-89)		

Name of member eligible to be a Qualified MedicareBeneficiary. Only the person whose name is in this block is eligible for Q.M.B. benefits.

Date of Birth shows month and year of birth of eligible individual.

QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B) CARD

(BACK OF CARD)

Information to Providers. including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through QMB.

PROVIDERS OF SERVICE

1. The individual named on this card is a qualified Medicare beneficiary and is eligible for Medicaid payment for Medicare part A and Part B Co-insurance and Deductables only.
2. Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:

Cabinet for Human Resources
Department for Medic..id Services
275 East Main Street
Frankfort, KY 40621-0001

Insurance Identification

A—Part A, Medicare Only
B—Part B, Medicare Only
C—Both Parts A & B Medicare
D—Blue Cross /Blue Sheild
E—Blue Cross /Blue Shield Major Medical
F—Private Medical Insurance
G—Champus
H—Health Mainentance Organization
J —Other and / or Unknown
L —Absent Parent's Insurance
M—None
N—United Mine Workers
P—Black Lung

RECIPIENT OF SERVICES

1. Show this card whenever you receive medical care.
2. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the front of the card immediately.
3. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.
6. If you have questions, contact your case worker at the Department for Social Insurance County office.

RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 205.624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-E

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD

(FRONT OF CARD)

Eligibility period is the month, day and year of KMAP eligibility represented by this card.
" From" date is first day of eligibility of this card.
"To" date is the day eligibility of this card ends and is not included as an eligible day.

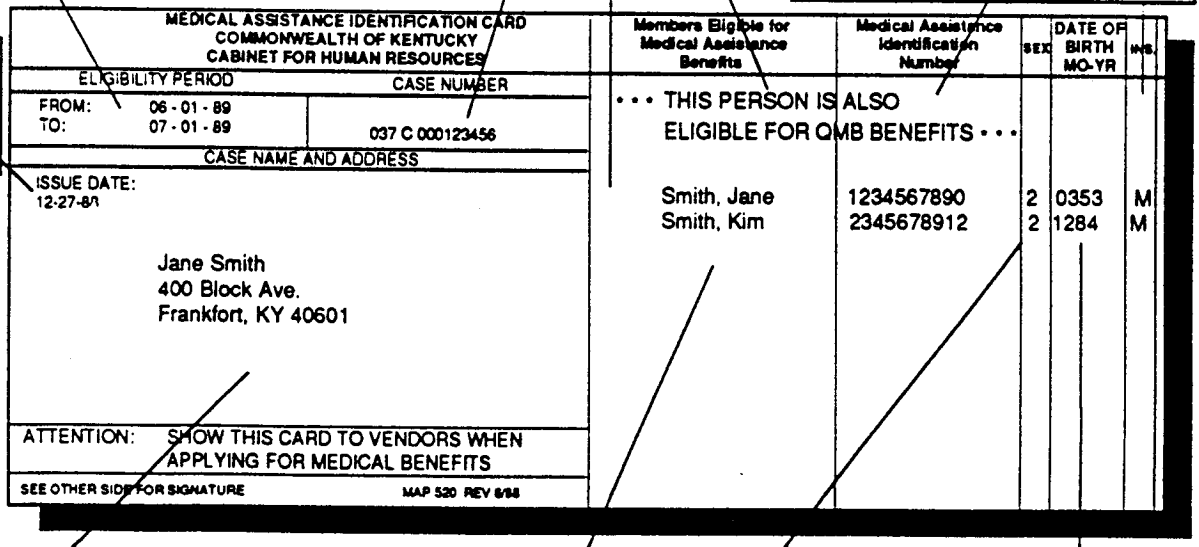
Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Medical Insurance Code indicates type of insurance coverage.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

NOTICE QMB Infro.

Date card was issued


MEDICAL ASSISTANCE IDENTIFICATION CARD
COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES

ELIGIBILITY PERIOD
FROM: 06 - 01 - 89
TO: 07 - 01 - 89

CASE NUMBER
037 C 000123456

CASE NAME AND ADDRESS

ISSUE DATE:
12-27-89

Jane Smith
400 Block Ave.
Frankfort, KY 40601

ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS

SEE OTHER SIDE FOR SIGNATURE

MAP 520 REV 6/88

Members Eligible for Medical Assistance Benefits

Medical Assistance Identification Number

SEX

DATE OF BIRTH MO-YR

RES.

• • • THIS PERSON IS ALSO ELIGIBLE FOR QMB BENEFITS • • •

Smith, Jane	1234567890	2	0353	M
Smith, Kim	2345678912	2	1284	M

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For K.M.A.P. Statistical Purposes

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for K.M.A.P. benefits.

Date of Birth shows month and year of birth of each member . Refer to this block when providing services limited to age.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD

(BACK OF CARD)

Information to Providers. Insurance Identification codes indicate type of insurance coverage as shown on the front of the card in "Ins." block.

This card certifies that the person(s) listed hereon is /are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources
Department for Social Insurance
Division of Medical Assistance
Frankfort, KY 40621

Insurance Identification

A Part A Medicare Only
B Part B Medicare Only
C Both Parts A & B Medicare
D Blue Cross Blue Shield
E Blue Cross Blue Shield Major Medical
F Private Medical Insurance
G Champus
H Health Mainentance Organization
J Other and or Unknown
L Absent Parent's Insurance
M None
N United Mine Workers
P Black Lung

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, durg stores, physicians, dentists, nursing homes, intermediate care facilities. Independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 205.624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.
Federal law provides for a $10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

MAP-343 (Rev. 5/86)

Provider Number: APPENDIX III
(If Known)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the ____ day of _____, 19___, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provider)

_____
(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

_____
(Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

(4) Agrees to maintain such records as are necessary to disclose the extent of services furnished to Title XIX recipients for a minimum of 5 years and for such additional time as may be necessary in the event of an audit exception or other dispute and to furnish the Cabinet with any information requested regarding payments claimed for furnishing services.

(5) Agrees to permit representatives of the state and/or federal government to have the right to examine, inspect, copy and/or audit all records pertaining to the provision of services furnished to Title XIX recipients. (Such examinations, inspections, copying and/or audits may be made without prior notice to the Provider.)

(6) Assures that he (it) is aware of Section 1909 of the Social Security Act; Public Law 92-603 (As Amended), reproduced on the reverse side of this Agreement and of KRS 194.500 to 194.990 and KRS 205.845 to 205.855 and 205.990 relating to medical assistance fraud.

(7) Agrees to inform the Cabinet for Human Resources, Department for Medicaid Services, within 30 days of any change in the following:

(a) name;
(b) ownership;
(c) licensure/certification/regulation status; or
(d) address.

(8) Agrees not to discriminate in services rendered to eligible Title XIX recipients on the basis of marital status.

(9) (a) In the event that the Provider is a specialty hospital providing services to persons aged 65 and over, home health agency, or a skilled nursing facility, the Provider shall be certified for participation under Title XVIII of the Social Security Act.

(b) In the event that the Provider is a specialty hospital providing psychiatric services to persons age 21 and under, the Provider shall be approved by the Joint Commission on Accreditation of Hospitals. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Hospitals.

(10) In the event that the provider desires to participate in the physician or dental clinic/corporation reimbursement system, Kentucky Medical Assistance Program payment for physicians' or dentists' services provided to recipients of the Kentucky Medical Assistance Program will be made directly to the clinic/corporation upon proper issuance by the employed physician or dentist of a Statement of Authorization (MAP-347).

This clinic/corporation does meet the definition established for participation and does hereby agree to abide by all rules, regulations, policies and procedures pertaining to the clinic/corporation reimbursement system.

2. In consideration of approved services rendered to Title XIX recipients certified by the Kentucky Medical Assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees, subject to the availability of federal and state funds, to reimburse the Provider in accordance with current applicable federal and state laws, rules and regulations and policies of the Cabinet for Human Resources. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services.

3. Either party shall have the right to terminate this agreement at any time upon 30 days' written notice served upon the other party by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, may terminate this agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or certified mail with return receipt requested.

4. In the event of a change of ownership of an SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.

5. In the event the named Provider in this agreement is an SNF, ICF, or ICF/MR/DD this agreement shall begin on _____, 19___, with conditional termination on _____, 19___, and shall automatically terminate on _____, 19___, unless the facility is recertified in accordance with applicable regulations and policies.

PROVIDER

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

PENALTIES

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

MAP-344 (Rev. 08/85)

KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Information

1. Name: _____

2. _____
Street Address, P.O. Box, Route Number (In Care of, Attention, etc.)

3. _____ _____ _____
City State Zip Code

4. _____
Area Code Telephone Number

5. _____
Pay to, In Care of, Attention, etc. (If different from above)

6. _____
Pay to Address (If different from above)

7. Federal Employer ID Number: _____

8. Social Security Number: _____

9. License Number: _____

10. Licensing Board (If Applicable): _____

11. Original License Date: _____

12. KMAP Provider Number (If Known): _____

13. Medicare Provider Number (If Applicable): _____

14. Provider Type of Practice Organization:

/_/ Corporation (Public)	/_/ Individual Practice	/_/ Hospital-Based Physician
/_/ Corporation (Private)	/_/ Partnership	/_/ Group Practice
/_/ Health Maintenance Organization	/_/ Profit	/_/ Non-Profit

15. If group practice, Number of Providers in Group (specify provider type):

_____

16. If corporation, name, address and telephone number of Home Office:

Name:_____

Address:_____

_____

Telephone Number:_____

Name and Address of Officers:

_____

_____

_____

_____

_____

17. If Partnership, name and address of Partners:

_____

_____

_____

_____

_____

18. National Pharmacy Number (If Applicable):_____
(Seven-Digit Number Assigned by National Pharmaceutical Association)

19. Physician/Professional Specialty:

1st_____

2nd_____

3rd_____

20. Physician/Professional Specialty Certification:

1st_____

2nd_____

3rd_____

21. Physician/Professional Specialty Certification Board:

1st_____ Date:_____

2nd_____ Date:_____

3rd_____ Date:_____

22. Name of Clinic(s) in Which Provider is a Member:

1st_____

2nd_____

3rd_____

4th_____

23. Control of Medical Facility:

/_/ Federal /_/ State /_/ County /_/ City /_/ Charitable or Religious

/_/ Proprietary (Privately owned) /_/ Other_____

24. Fiscal Year End:_____

25. Administrator:_____ Telephone No._____

26. Assistant Administrator:_____ Telephone No._____

27. Controller:_____ Telephone No._____

28. Independent Accountant or CPA:_____ Telephone No._____

29. If sole proprietorship, name, address, and telephone number of owner:

Name:_____

Address:_____

Telephone No._____

30. If facility is government owned, list names and addresses of board members:

	Name	Address
President or Chairman of Board:		
Member:		
Member:		
Member:		
Member:		

31. Management Firm (If Applicable):

Name: _____

Address: _____

32. Lessor (If Applicable):

Name: _____

Address: _____

33. Distribution of Beds in Facility (Complete for all levels of care):

	Total Licensed Beds	Total Title XIX Certified Beds
Hospital Acute Care		
Hospital Psychiatric		
Hospital TB/Upper Respiratory Disease		
Skilled Nursing Facility		
Intermediate Care Facility		
ICF/MR/DD		
Personal Care Facility		

34. SNF, ICF, ICF/MR/DD Owners with 5% or More Ownership:

Name	Address	Percent of Ownership

35. Institutional Review Committee Members (If Applicable):

_____

_____

_____

_____

_____

36. Providers of Transportation Services:

No. of Ambulances in Operation:_____ No. of Wheelchair Vans in Operation:_____

Total No. of Employees:_____ (Enclose list of names, ages, experience & Training.)

Current Rates:

A. Basic Rate $_____ (Includes up to _____ miles.)

B. Per Mile $_____

C. Oxygen $_____

D. Extra Patient $_____

E. Other

_____ $_____

37. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medical Assistance Program.

Signature: _____

Name:_____

Title:_____ Date:_____

INTER-OFFICE USE ONLY

License Number Verified through_____(Enter Code)

Comments:_____

_____

Date:_____ Staff:_____

ATTENDIX V

1	2	3 PATIENT CONTROL NUMBER	4 TYPE OF BILL

5 BC/BS PROV. NO.	6 FEDERAL TAX NO.	7 MEDICARE NO.	8 MEDICAID NO.	9

10 PATIENT'S LAST NAME	FIRST NAME	INITIAL	11 PATIENT'S ADDRESS	CITY	STATE	ZIP

BIRTH DATE	13 SEX	14 MS	ADMISSION 15 DATE	16 HR.	17 TYPE	18 SRC	19 A.H.	20 D.H	21 STAT	22 STATEMENT COVERS PERIOD FROM	THROUGH	23 COV D.	24 N-C.D.	25 C-I.D	26 L-R.D	27

28 OCCURRENCE CD	DATE	29 OCCURRENCE SPAN CD	DATE	30 OCCURRENCE CD	DATE	31 OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	35 OCCURRENCE SPAN CD	FROM	THROUGH

34

CONDITION CODES 35	36	37	38	39	BLOOD RECORD (PINTS) 40 FURN	41 REPL	42 NOT RP	43 DED	44 SP PROG.	45

46 VALUE CD	AMT	47 VALUE CD	AMT	48 VALUE CD	AMT	49 VALUE CD	AMT
a							
b							

50 DESCRIPTION	51 R.CODE	52 S.UNITS	53 TOTAL CHARGES	54	55	56

57 PAYER	58 REL INFO	59 ASG BEN	60 DEDUCTIBLE	61 COINSURANCE	62 EST RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST AMOUNT
A							
B							
C							

DUE FROM PATIENT ▶

65 INSURED'S NAME	66 SEX	67 P REL	68 INSURED'S SSN/HIC ID NO	69 GROUP NAME	70 INSURANCE GROUP NO
A					
B					
C					

71 P.S.R.O.	72 ESC	73 EMPLOYER NAME	74 EMPLOYER ID	75 EMPLOYER LOCATION

PSRO JUR DATA 76 APP FROM	77 APP THROUGH	DIET

REMARKS

FOR INTERMEDIARY USE ONLY						
FROM	THROUGH	PR PSC ID				
AMT REIMBURSED		CD			APPROV BY	DATE APPROV

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

PROVIDER REPRESENTATIVE X

96 DATE

UB-82 HCFA-1450

Election of Medicaid Hospice Benefit

I, _____ / _____ , elect to receive the Medicaid
(Patient Name/ MAID#)

Hospice Benefit from _____ / _____ this _____ day of
(Facility Name) (Provider Number)

_____, 19 ____. I am aware that my disease is incurable. I consent to the management of the symptoms of my disease by _____. My family and I will help to develop a plan of care based on our needs. My care will be supervised by my attending physician, _____, and the Hospice Director. My outpatient medications will be provided by _____

I may receive benefits which include home nursing visits, counseling, medical social work services, medical supplies and equipment. If needed, I may also receive home health aides/homemakers, physical therapy, occupational therapy, speech/language pathology, in-patient care for acute symptoms, medical procedures ordered by my physician and hospice, and continuous nursing care in the home in acute medical crisis.

I may request volunteer services, when available.

I realize that my family and I have the opportunity for limited respite or relief care in a nursing facility.

In accepting these services, which are more comprehensive than regular Medicaid benefits, I waive my right to regular benefits except for payment to my attending physician, treatment for medical conditions unrelated to my terminal illness, medical transportation, nurse anesthetist, or dental.

I understand that I can revoke this benefit at any time and return to regular Medicaid benefits. I understand, if I terminate the Medicaid Hospice Benefit, I can resume regular Medicaid if I am still eligible.

I understand that the Hospice Benefit is a home care program. If my family and I choose care not available from the Hospice Agency, I understand that the Hospice and the Medicaid Program are not financially responsible.

I understand that the Hospice Benefit consists of three non-renewable benefits periods – two ninety-day periods, and one thirty-day period. I may be responsible for hospice charges if I exhaust my Medicaid Hospice Benefits, or if I become ineligible for Medicaid services.

I understand that at the end of either the first ninety-day period or the second, because of an improvement in my condition, I may choose to save the remainder of the benefit period(s). I may revoke the Hospice Benefit at that time.

I also understand that should I choose to do so, I am still eligible to receive the remaining benefit period(s); I am aware, however, that if I choose to revoke Hospice Benefits during a benefit period, I am not entitled to coverage for the remaining days of that benefit period.

I understand that if I choose to do so, once during each election period I may change the designation of the particular hospice from which hospice care will be received by filing a statement with the hospice from which care has been received and with the newly designated hospice. I understand that a change of hospice providers is not a revocation of the remainder of that election period.

I understand that, unless I revoke the Hospice Benefit, hospice coverage will continue for 210 consecutive days.

I understand that if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefit.

Check one:

☐ I am a Medicare recipient and have elected to use the Medicare Hospice Benefit. My Medicare eligibility for hospice benefits begins _____.

☐ I am not a Medicare recipient.

☐ My Medicare Hospice Benefits have been exhausted as of _____.
(Date)

☐ I am currently a long term care facility resident, residing at:

_____
(Facility Name/ Address)

Type of Facility: ☐ Skilled Nursing Facility ☐ Intermediate Care Facility

Hospice Benefit Election

Patient's Signature or Mark	Patient's Name (Print or Type)
Witness' Signature	Relationship to Patient
Date Signed	Effective Date of Election

.....

Second Certification Period: (To be signed only if benefits previously revoked or temporarily terminated)

Patient's Signature or Mark	Patient's Name (Print or Type)
Witness' Signature	Relationship to Patient
Date Signed	Effective Date of Second Period

.....

Third Certification Period: (To be signed only if benefit previously revoked or temporarily terminated)

Patient's Signature or Mark	Patient's Name (Print or Type)
Witness' Signature	Relationship to Patient
Date Signed	Effective Date of Third Period

MAP-375 (8/88)

Revocation of Medicaid Hospice Benefits

I, _____/_____ revoke the hospice benefit allowed
(Patient Name/MAID #)

to me by Medicaid and rendered by _____
(Hospice Agency)

_____ this _____ day of _____, 19____.
(Provider #)

I understand that any remaining days of this election period will not be available to me.

I understand that I may elect hospice care at a later time if this revocation has occurred during either of the two initial 90-day benefit periods.

I understand that as of the date of this revocation, if I am still eligible, my regular Medicaid benefits will be restored.

_____ _____
Patient's Signature Witness' Signature

_____ _____
Date Date

FOR OFFICE USE ONLY

Rationale of Revocation:_____

_____

_____

_____

_____

_____

_____

MAP-376 (8/88)

Change of Hospice Providers

I _____ wish to change the designation of
(Patient Name/MAID #)

the particular hospice from which I receive hospice care. I no longer wish to receive hospice service from _____, but
(Provider Name/Number)

instead wish to receive hospice care from _____,
(Provider Name/Number)

effective this _____ day of _____, 19_____.

I understand that this change of hospice providers is not a revocation of the remainder of this election period.

_____ _____
Patient's Signature or Mark Witness' Signature

_____ _____
Date Date

MAP-403 (8/88)

Hospice Patient Status Change

The status of _____ / _____ who has been
Patient Name MAID #

receiving hospice benefits from _____
Hospice Agency

_____ since _____ has changed as indicated below.
Provider # Date of Election

As of _____
Date

/_/ Patient's Medicare benefits have been exhausted.

/_/ Patient has become eligible for Medicare benefits.

/_/ Patient is a resident at _____ which is
Name of Facility

a /_/ skilled nursing /_/ intermediate care facility.

/_/ Patient has changed levels of care. Patient has transferred from

_____ which is a /_/ skilled nursing
Name of Facility

/_/ intermediate care facility to _____
Name of Facility

which is a/_/ skilled nursing /_/ intermediate care facility.

/_/ Patient has returned to a home setting and is no longer a resident at

_____
Name of Facility

/_/ Patient is in long term/inactive status due to improvement in condition.

_____ will continue to
Hospice Agency

follow patient, but active hospice benefits are temporarily discontinued. Patient may return to active status at any time a change in condition necessitates with no loss of remaining benefit period(s). Patient has used _____ days of 210-day benefit period.

/_/ Patient elects to return to active status after having been in inactive status since _____. Patient has _____ days remaining in 210-day benefit
Date

period.

/_/ OTHER (Please describe any other change in patient status.)

_____

_____

_____ _____

Patient Signature Hospice Agency Representative Signature

APPENDIX X

MAP-378 (8/88)

Termination of Medicaid Hospice Benefits

Hospice benefits for _____/_____ are hereby
(Patient Name/MAID #)
terminated effective _____, 19____, for the following reason.

/_/ Patient is deceased. Date of death is _____, 19_____.

/_/ Patient has not requested extension of Medicaid hospice benefits.

/_/ Patient has used maximum lifetime hospice benefit days.

/_/ OTHER (Please clarify) _____

_____

_____

_____

/_/ Condition improved. Patient in Long Term/Inactive Status.

_____
(Hospice Agency) (Provider #)

will continue to follow patient but active hospice benefits are temporarily discontinued. Patient may return to active status any time change in condition necessitates with no loss of remaining benefit periods.

_____/_____
Hospice Agency Provider #

_____
Hospice Medical Director

_____
Date

MAP-379 (1/87)

Representative Statement
For Election of Hospice Benefits

I, _____, due to the physical/
(Legal Representative)
mental incapacity of _____/_____ am authorized
(Patient Name/MAID #)
in accordance with state laws to execute, change or revoke the election of Medicaid Hospice Benefits on behalf of _____ who has been certified as terminally ill. As the representative for _____, I will sign all necessary forms.

_____
Signature, Legal Representative

_____
Date

_____
Witness

_____
Date

AS OF 09/10/86 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOSPICE SERVICES

* PAID CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	CHARGES NOT COVERED	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
023104	DONALDSON R	3834042135	9883324-552-580	010186-010186	50.00	2.00	0.00	48.00	365
01 PS 3	PROC 01234	QTY 5		010286-010286	30.00	0.00		30.00	61
02 PS 3	PROC 12345	QTY 5		010386-010386	20.00	2.00		18.00	365

CLAIMS PAID IN THIS CATEGORY: 1 TOTAL BILLED: 50.00 TOTAL PAID: 48.00

APPENDIX XII - P.1

AS OF 09/10/86 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOSPICE SERVICES

* CLAIMS IN PROCESS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	EOB
571384	JOHNSON P	2471340401	9883342-564-210	010286-010286	32.00	260
574632	MITCHELL J	4331740410	9883347-575-240	010286-010286	24.00	260

CLAIMS PENDING IN THIS CATEGORY: 2 TOTAL BILLED: 56.00

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOSPICE SERVICES

DESCRIPTION OF EXPLANATION CODES LISTED ABOVE

061	PAID IN FULL BY MEDICAID
254	THE RECIPIENT IS NOT ELIGIBLE ON DATES OF SERVICE
260	ELIGIBILITY DETERMINATION IS BENG MADE
365	FEE ADJUSTED TO MAXIMUM ALLOWABLE
999	REQUIRED INFORMATION NOT PRESENT

PROVIDER INQUIRY FORM

EDS
P.O. Box 2009
Frankfort, Ky. 40602

Please remit **both** copies of the Inquiry Form to EDS.

1. Provider Number	3. Recipient Name (first, last)
2. Provider Name and Address	4. Medical Assistance Number
	5. Billed Amount / 6. Claim Service Date
	7. RA Date / 8. Internal Control Number

9. Provider's Message

10. _____
Signature Date

Dear Provider:

_____ This claim has been resubmitted for possible payment.

_____ EDS can find no record of receipt of this claim. Please resubmit.

_____ This claim paid on_____in the amount of_____.

_____ We do not understand the nature of your inquiry. Please clarify.

_____ EDS can find no record of receipt of this claim in the last 12 months.

_____ This claim was paid according to Medicaid guidelines.

_____ This claim was denied on_____for EOB code _____

_____

_____ Aged claim. Payment may not be made for services over 12 months old without proof that the claim was received by EDS within one year of the date of service; and if the claim rejects, you must show timely receipt by EDS within 12 months of that rejection date. Claims must be received by EDS every 12 months to be considered for payment.

Other:_____

_____

_____

_____

_____

_____
EDS Date

MAIL TO: EDS FEDERAL CORPORATION
P.O. BOX 2009
FRANKFORT, KY 40602

ADJUSTMENT REQUEST FORM

1. Original Internal Control Number (I.C.N.)	EDS FEDERAL USE ONLY	
2. Recipient Name	3. Recipient Medicaid Number	
4. Provider Name/Number/Address	5. From Date Service	6. To Date Service
	7. Billed Amt.	8. Paid Amt. / 9. R.A. Date

10. Please specify WHAT is to be adjusted on the claim.

11. Please specify REASON for the adjustment request or incorrect original claim payment.

IMPORTANT: THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY OF THE CLAIM AND REMITTANCE ADVICE TO BE ADJUSTED.

12. Signature 13. Date

EDSF USE ONLY---DO NOT WRITE BELOW THIS LINE

Field/Line:

New Data:

Previous Data:

Field/Line:

New Data:

Previous Data:

Other Actions/Remarks:

THIRD PARTY LIABILITY PROVIDER LEAD FORM

DATE:

PROVIDER NAME:_____ PROVIDER #:_____

RECIPIENT NAME:_____ MAID:_____

BIRTHDATE:_____ ADDRESS:_____

DATE OF SERVICE:_____TO_____ DATE OF ADMISSION:_____

DATE OF DISCHARGE:_____ NAME OF INS. CO.:_____

POLICY #:_____ CLAIM NO.:_____

AMOUNT OF EXPECTED BENEFITS:_____

MAIL TO: EDS Federal Corporation
Fiscal Agent for KMAP
ATTN: TPL Unit
P.O Box 2009
Frankfort, KY 40602

MAP-552
(R. 4/88)

COMMONWEALTH OF KENTUCKY
Cabinet for Human Resources
Department for Social Insurance

NOTICE OF AVAILABILITY OF INCOME
FOR LONG TERM CARE/WAIVER
AGENCY/HOSPICE

APPENDIX XVI

A.
Case Name _____
[ ] Committee [ ] Payee
Case No. _____

B. [ ]Initial [ ]Change

C. Client's Name _____ Birth Date _____ (Mo./Yr.) [ ]Title XVIII [ ]Title XIX

D. Current Facility/
Waiver Agency/Hospice _____ Address _____

[ ]SNF [ ]ICF [ ]ICF/MR
[ ]MH/PSY [ ]HCBS
[ ] AIS/MR [ ]Hospice

Actual Admission Date to
this Facility/Waiver Agency/Hospice _____
Date of Discharge or
Date of Death (If Applicable) _____

E. Previous Facility/
Waiver Agency/Hospice _____ Address _____

Admission Date _____ Date of Discharge _____ Type: [ ]SNF [ ]ICF [ ]ICF/MR [ ]MH/PSY [ ]FCH
[ ]PCH [ ]HCBS [ ]AIS/MR [ ]Hospice

F. Family Status

1. [ ]Single [ ]Married No. of Children _____

Total Dependents _____

2. Spouse
[ ]Ineligible [ ]Eligible [ ]Patient [ ]Non-Patient

_____
(Co.) (Prg.) (Number)

G. Income Computation

1. Unearned Income

Source of Unearned Income	Amount
a. RSDI (Including SMI if dedct. by SSA)	
b. SSI	
c. RR (Including SMI, if dedct. by RR)	
d. VA	
e. State Supplementation	
f. Other (Specify) _____	
g. Sub-Total Unearned Inc. (1a thru 1f)	$

2. Earned Income

	Amount
a. Income _____ (Source)	
b. Earned Income Deduction(s)	-
c. Sub-Total Earned (2a-2b)	$

3. Total Income (1g plus 2c) $

4. Deductions

	Amount
a. Incurred Medical Expenses (Exclude Health Ins. of Client)	
b. Health Insurance 1) SMI (JKM Only)	
2) Other Health Ins.	
c. Spouse/Family Maintenance	
d. Personal Needs Allowance	$
e. Total Deductions (4a thru 4d)	$

5. Available Income (3 minus 4e) $

6. Available Income (rounded) $

H. Explain Incurred Medical Expenses

List full names and policy numbers of all health insurance policies.

I. Status

1. Active Case [ ]Yes [ ]No
2. If active, Eff. Date for MA _____
3. If discontinued, Eff. Date of MA Disc. _____
4. Program Code Change [ ]Yes [ ]No
From _____ To _____ Eff. _____
5. SSI Entitlement Confirmed
Confirmation Date _____
6. Available Monthly Income (Item G-6) _____
Effective Date (Change forms only) _____

J. Comment Section

1. [ ]LO1 [ ]MAP-24 [ ]MAP-374
[ ]DMS Letter of Approval
[ ]DMR-001. . . . . _____
(Date Received)

2. Corrected MAP-552
Correction of MAP-552 dated _____

3. [ ]Private Pay Patient
From _____ to _____

4. [ ]PAFS-105. . . Date Sent _____

5. Additional comments:

K.

_____
(Signature) (Date)

MAP-383 (11/88)

Other Hospitalization Statement

This is to certify that hospitalization at

_____
Name of Facility

for _____ beginning on
Recipient Name/MAID Number

_____ is not related to the terminal illness of this
Date of Admission

patient.

The reason for this admission is _____ / _____
Diagnosis ICD 9 CM Code

This patient's terminal illness is _____ / _____
Diagnosis ICD 9 CM Code

Charges for this hospital stay should not be billed to the hospice agency but should be billed directly to the Kentucky Medical Assistance Program.

Signed: _____
Medical Director

_____
Hospice Agency

_____
Date

Please attach documentation verifying that hospitalization is not related to terminal illness.

Is this the first time this patient has been hospitalized for a condition not related to the terminal illness? /_/ Yes /_/ No

If no, dates of previous admission _____

Diagnosis for previous admission _____
ICD 9 CM Code

/_/ Approved by the KMAP /_/ Denied by the KMAP

_____
KMAP Signature Date

MAP-384 (8/88)

HOSPICE DRUG FORM

1. Recipient Last Name	2. First Name	3. Medical Assistance I.D. No.

4. Date Medicaid Hospice Coverage Began	5. (1) First Diagnosis (Not Related to Terminal Illness)	ICD.9 CM Code
6. Total Number of Prescriptions Not Related to Terminal Illness	(2) Second Diagnosis (Not Related to Terminal Illness)	ICD.9 CM Code

7. Drug Name Manufacturer/Strength (10 mg, 15 ml, etc.)	8. NDC #	9. Units	10. Price Per Unit	11. Total Charge	12. Medicaid Maximum Allowance (Leave Blank)
		13. Total Units This Invoice		14. Total Charge This Invoice	

15. Terminal Diagnosis	ICD. 9 CM Code	16. Did Patient Require These Prescriptions Prior to Diagnosis or Terminal Illness? ___ YES ___ NO

17. Are These Prescriptions the Result of Hospitalization not Related to Terminal Illness?

___ YES ___ NO

18. If yes, Dates of Hospitalization:

FROM _____ TO _____

19. Name of Hospital	20. Prescribing Physician

21. PROVIDER CERTIFICATION AND SIGNATURE: This is to certify that the prescriptions entered above are not related to the terminal illness of this recipient.

Signed _____

22. PROVIDER NAME AND ADDRESS	23. PROVIDER NUMBER	24. INVOICE DATE	25. INVOICE NUMBER

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HOSPICE PROGRAM APPENDICES

SECTION I - INTRODUCTION

I. INTRODUCTION

This new edition of the Kentucky Medical Assistance Program Hospice Program Manual has been formulated with the intention of providing you, the provider with a useful tool for interpreting the procedures and policies of the Kentucky Medical Assistance Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will, hopefully, assist you in understanding what procedures are reimbursable, and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning general agency policy should be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Division of Policy and Provider Services, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-6890. Questions concerning billing procedures or the specific status of claims should be directed to EDS, P.O. Box 2009, Frankfort, KY 40602, or Phone (800) 333-2188[~~372-2921~~] or (502) 227-2525.

SECTION I - INTRODUCTION

B. Fiscal Agent

Effective December 1, 1983, Electronic Data Systems (EDS) will provide fiscal agent services for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS will receive and process all claims for medical services provided to Kentucky Medicaid recipients.

SECTION IV - CONDITIONS OF PARTICIPATION

IV. CONDITIONS OF PARTICIPATION

A. Provider Participation Requirements

In order to be eligible to participate in the Kentucky Medical Assistance Program as a provider of Hospice services, the Hospice must first be licensed by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board to provide hospice services in accordance with the requirements set forth in 902 KAR 20:140, and be certified by Title XVIII, Medicare, as a provider of hospice services. Further, the hospice must meet any additional certification requirements of the Title XIX program as outlined in 907 KAR 1:330 in the provision of covered hospice services required to meet the needs of the client. These services may be provided directly or through written contractual arrangements with another individual or entity for which the participating provider will be held responsible.

B. Application for Participation

An application for participation in the Title XIX Hospice Program element shall consist of the following:

1) Participation Agreement (MAP-343)
2) Provider Information Form (MAP-344)
3) Copy of Medicare form listing Medicare payment rates
4) Copy of Medicare Certification Letter
5) Copy of Certificate of Need

Copies of the Participation Agreement and Provider Information Form may be found in Appendix III and IV of this manual.

The completed Application for Participation should be sent to the following address:

Cabinet for Human Resources
Department for Medicaid Services
Provider Enrollment
275 East Main Street
Frankfort, KY 40621

Approval of an Application for Participation will include a signed copy of the Agreement and notification of the billing provider number.

SECTION IV - CONDITIONS OF PARTICIPATION

C. Change in Service Area

If there is a change in the provider's service area (adding or deleting a county or counties to be served) a copy of the new Certificate of Need identifying that change must be sent to the Department for Medicaid Services as soon as it is received by the provider so that the local Department for Social Insurance Offices can be notified that the provider is now available or unavailable in that county.

D[~~C~~]. Licensure

Employees who provide hospice services must be licensed, certified or registered in accordance with applicable Federal or state laws.

E[~~D~~]. Medical Director

The medical director must be a hospice employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's patient care program.

F[~~E~~]. Continuation of Care

A hospice may not discontinue or diminish care provided to a Medicaid beneficiary because of the beneficiary's inability to pay for that care.

G[~~F~~]. Informed Consent

A hospice must demonstrate respect for an individual's rights by ensuring that an informed consent form that specifies the type of care and services that may be provided as hospice care during the course of the illness has been obtained for every individual, either from the individual or the individual's representative.

SECTION IV - CONDITIONS OF PARTICIPATION

H[~~G~~]. Interdisciplinary Group

1. The hospice must designate an interdisciplinary group or groups composed of the following individuals who are employees of the Hospice and who provide or supervise the care and services offered by the hospice.

   a. a doctor of medicine or osteopathy
   b. a registered nurse
   c. a social worker
   d. a pastoral or other counselor

2. The interdisciplinary group is responsible for the following:

   a. participation in the establishment of the plan of care

   b. provision or supervision of hospice care and services

   c. periodic review and updating of the plan of care for each individual receiving hospice care

   d. establishment of policies governing the day-to-day provision of hospice care and services.

3. If a hospice has more than one interdisciplinary group, it must designate in advance the group it chooses to execute the functions described above.

4. The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

I[~~H~~]. Plan of Care

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan.

1. The plan must be established by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care.

2. The plan must be reviewed and updated at intervals specified in the plan by the attending physician, the medical director, or physician designee and interdisciplinary group. These reviews must be documented.

3. The plan must include the assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

J[~~I~~]. Medical Records

1. Medical records must substantiate the services billed to the KMAP by the hospice. The medical records must be accurate and appropriate and must include the following:

   a. the initial and subsequent assessments
   b. the plan of care
   c. identification data
   d. consent and authorization and election forms
   e. pertinent medical history
   f. complete documentation of all services and events (including evaluations, treatments, progress notes, etc.)

2. All records must be signed by the staff person providing the service and dated.

3. Medical records must be maintained for a minimum of five years and for any additional time as may be necessary in the event of an audit exception or other dispute. The records and any other information regarding payments claimed must be maintained in an organized central file and furnished to employees of the Cabinet for Human Resources or Federal Government upon request, and made available for inspection and/or copying by Cabinet personnel.

SECTION IV - CONDITIONS OF PARTICIPATION

K[~~J~~]. Termination of Participation

907 [~~904~~] KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medical Assistance Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;

2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;

3. Misrepresenting factors concerning a facility's qualifications as a provider;

4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or

5. Submitting false or questionable charges to the agency.

The Kentucky Medical Assistance Program shall notify a provider in writing at least fifteen (15) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice will state:

1. The reasons for the decision;

2. The effective date;

3. The extent of its applicability to participation in the Medical Assistance Program;

4. The earliest date on which the Cabinet will accept a request for reinstatement;

5. The requirements and procedures for reinstatement; and

6. The appeal rights available to the excluded party.

The provider receiving such notice may request an evidentiary hearing. The request must be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Human Resources. When an evidentiary hearing is held, the provider is entitled to the following:

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;

2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;

3. Counsel representing the provider;

4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and

5. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of the Cabinet for Human Resources.

These procedures apply to any individual provider who has received notice from the Cabinet of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Kentucky Medical Assistance Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medical Assistance Program. Adverse action taken against an individual provider under Medicare must be appealed through Medicare procedures.

SECTION IV - CONDITIONS OF PARTICIPATION

L. Annual Recertification

In accordance with Federal requirements, a hospice provider's certification and participation with the KMAP must run concurrently with the provider's license issued by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board. Since hospice agencies are re-licensed annually, it will be necessary for hospice providers to be recertified with the KMAP on an annual basis.

If for any reason a hospice provider's license is not renewed, that provider's participation with the KMAP will be terminated and no payment will be made to the provider for services rendered after the expiration date of the previous year's license until such time as notification of relicensure is received by the KMAP.

Upon receipt of notification of relicensure, the provider will be recertified with the KMAP for the entire period of time covered by the new license.